STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012798	A. BUILDING: _____ B. WING _____	C 06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF GREENFIELD	831 SWOPE STREET GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00150325. Complaint IN00150325 Substantiated. No deficiencies related to the allegations are cited. Survey Date: June 26 2014 Facility number: 012798 Provider number: 012798 AIM number: NA Survey team: Chuck Stevenson RN Census bed type: Residential: 50 Total: 50 Census payor type: Medicaid: 17 Other: 33 Total: 50 Sample: 3 Crownpointe of Greenfield was was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00150325. Quality Review 06/27/14 by Lisa McColly	R 000		